Family Opportunity Act Medicaid Buy-In Program

Medicaid health care coverage is available to children under age 19 who meet the federal childhood disability definition. Income limits for children with disabilities are higher than for other Medicaid Programs.

NO enrollment fees, co-payments, or deductibles

To Qualify

- Your child must meet the SSI childhood disability definition;
- Family gross income must be below the amounts shown in the chart;
- Parents must sign up for or keep health insurance through their job if the employer pays at least 50% of the premiums;
- Some families will not pay a premium: most will pay $12 to $35 per month for the Medicaid coverage; and
- You must meet other program requirements.

We Review Your Family's Income

We count your family's gross income, not take-home (net) pay, and compare it to the family size. A *family* includes the child who is applying, parents (legal and natural), and sisters and brothers under the age of 19 who live in the home. We **do not** count things like bank accounts, your home, vehicles, or land.

Income Limits Effective April 1, 2010 through March 31, 2011	
Family Size	**Monthly**
1	$2,708
2	$3,643
3	$4,578
4	$5,513
5	$6,448
6	$7,383
Each extra person	Add $935

How to Apply

- **Online** – **www.Medicaid.DHH.Louisiana.gov**
- **Mail** -
  Family Opportunity Act
  P.O. Box 91278
  Baton Rouge, LA 70821-9278
- **FAX - 1-877-523-2987** (toll free)
- **Drop Off –** Go to your local Medicaid office. To find the closest office call us at **1-888-342-6207**, or visit **www.Medicaid.DHH.Louisiana.gov**

After You Apply

We will let you know if your child qualifies. If they do, you will get a plastic Medicaid card about two weeks following the approval letter. If they already have a Medicaid card, we will reactivate it, and you can start using it as soon as you hear from us.

Covered Services

Doctor visits	Hospital care
Prescriptions	Shots
Lab work and tests	X-rays
Mental health	Psychological tests
Psychological therapy	Physical therapy
Speech therapy	Occupational therapy
Dental, vision, hearing	Medical transportation

Medical supplies and equipment
And all other Medicaid services for children.

Your child may use any doctor or clinic who accepts Medicaid. If you have other insurance Medicaid pays after your other health insurance has paid.

Questions

Call **1-888-342-6207**

TTY text telephone users:
1-800-220-5404

These calls are free.

← (TEAR OFF THE APPLICATION HERE BEFORE MAILING. KEEP THIS PAGE FOR YOURSELF.)

Your Rights

If you think the decision we make is unfair, not correct or made too late, you may ask for a fair hearing.

- ✓ Call the Family Opportunity Act Medicaid Buy-In Program office at 1-888-342-6207; and/or
- ✓ Write to:
  LA DHH Bureau of Appeals
  P.O. Box 4183
  Baton Rouge, LA 70821-4183

The Family Opportunity Act Medicaid Buy-In Program is an Equal Opportunity Program

We cannot treat you differently because of your race, color, sex, age, disability, religion, nationality or political beliefs. If you think we have:

- ✓ Call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019;
- ✓ Call the Family Opportunity Act Medicaid Buy-In Program office at 1-888-342-6207, TTY text telephone users call 1-800-220-5404; and/or

- ✓ Write to:
  LA Department of Health & Hospitals
  P.O. Box 4818
  Baton Rouge, LA 70821-4818

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¿Necesita traductor de español? Llame al 1-877-252-2447.

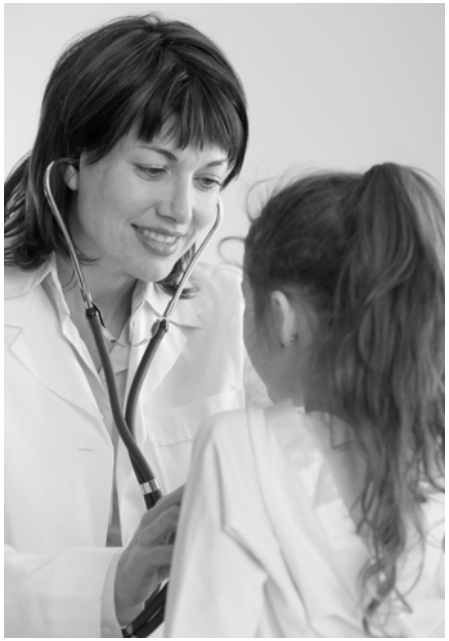
Quí vị có cần thông dịch viên người Việt không? Nếu cần xin gọi số 1-877-252-2447.

LOUISIANA
Department of HEALTH and HOSPITALS

BHSF Form 1-FOA Cover
Revised 04/10

Family Opportunity Act Medicaid Buy-In Program

for Children with Disabilities



Let Us Be Your Partner in Health

1-888-342-6207

Apply Online
www.Medicaid.DHH.Louisiana.gov

Louisiana Department of Health & Hospitals

BHSF Form 1-FOA
Rev. 04/10
Prior Issue Obsolete

FAMILY OPPORTUNITY ACT MEDICAID BUY-IN PROGRAM APPLICATION

Interviewer: _____

Date of Interview: _____

Louisiana's Family Opportunity Act Medicaid Buy-In Program provides complete health care for **children under age 19 who have a physical, mental, or developmental disability**. If required, families will pay $12 to $35 per month for this coverage. Parents who have health insurance available through their employer are required to enroll the child as a condition of eligibility.

If you are applying for more than one child, please fill out separate applications for each child.

To apply using this application:

1. Fill it out and sign it. Use a black ink pen.
2. Get together the documents of proof we need.
3. Mail or fax the form and documents of proof to:

Family Opportunity Act Medicaid Buy-In Program
P.O. Box 91278
Baton Rouge, LA 70821-9278
FAX # (toll free): 1-877-523-2987

What language do you speak best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other (specify)* _____
What language do you write best? ❑ *English* ❑ *Spanish* ❑ *Vietnamese* ❑ *Other (specify)* _____

1. Where did you get this application form?

❑ Medicaid Office ❑ Hospital ❑ Pharmacy ❑ Doctor's Office ❑ Friend/Relative ❑ Internet
❑ School Clinic ❑ Food Stamp Office ❑ Health Unit ❑ Business (Store, Work) ❑ Festival/Health Fair
❑ Somewhere else: _____

2. Parent or Caregiver Information (List second parent or caregiver in Question 3)

Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number _____ Date of Birth (month, day, year) _____

Relationship to Child Applying: ❑ Parent ❑ Stepparent ❑ Grandparent ❑ Other: _____

Race/Ethnic Background (Optional- you may mark one or more): ❑ White ❑ Black ❑ Asian ❑ Hispanic or Latino
❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Other: _____

Mailing Address _____
P.O. Box or Street Address *Apartment/Lot Number*

_____
City *State* *Zip Code*

Home Address (*if different)* _____
Street Address *Apartment/Lot Number*

_____
City *State* *Zip Code*

Parish _____ E-mail Address _____

Home Phone (____) _____ Cell Phone (____) _____ Daytime Phone (____) _____

Best Day and Time to Call During our Office Hours (Mon-Fri, 8:00 am – 4:30 pm) _____

Questions? Call 1-877-252-2447

TTY Text Telephone For The Hearing Impaired, Call 1-800-220-5404

3. Does another parent or caregiver live in the home? ❑ Yes – Answer Questions Below ❑ No – Go to Question 4

Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____ Date of Birth (month, day, year)_____

Relationship to Child Applying: ❑ Parent ❑ Stepparent ❑ Grandparent ❑ Other: _____

4. Child with Disability

If you are applying for more than one child, please fill out a separate application for each child.

Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____ Date of Birth (month, day, year)_____

Race/Ethnic Background (Optional- you may mark one or more): ❑ White ❑ Black ❑ Asian ❑ Hispanic or Latino ❑ American Indian or Alaska Native ❑ Native Hawaiian or Pacific Islander ❑ Other: _____

Place of Birth: State (if born in the U.S.)_____ Country (if born outside the U.S.)_____

Mother's Name _____
First *(Maiden Name)* *Last*

Is this child a U.S. citizen? ❑ Yes – Go to Question 5 ❑ No – Answer the next questions

Is this child a lawful permanent resident? ❑ Yes ❑ No - What date did he come to the U.S.? _____

Permanent Resident Card (green card) Number **A#**_____

5. Has the child ever received Supplemental Security Income (SSI) benefits? ❑ Yes – Fill Out Below ❑ No – Go to Question 6

When did it end? _____

Why did it end? _____

6. List the child's brothers and sisters under age 19 who live in the home. ❑ None – Go to Question 7

Do not list step-brothers and step-sisters. If there are more than three children, use another sheet of paper.

A. Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____ Date of Birth (month, day, year)_____

B. Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____ Date of Birth (month, day, year)_____

C. Name _____ ❑ Male ❑ Female
First *Middle Initial* *Last*

Social Security Number_____ Date of Birth (month, day, year)_____

7. Does the child who is applying have health insurance? ❑ Yes – Fill Out Below ❑ No – Go to Question 8

If more than one health insurance, use another sheet of paper.

Policyholder's Name _____ Coverage Start Date _____

Insurance Name and Phone Number _____

Policy Number _____ Group Number _____

What does the policy cover? ❑ Hospital ❑ Doctor ❑ Medicine ❑ Dental ❑ Ambulance

Who pays the premium? _____

If the insurance is through a job, name of employer: _____

When is open enrollment? _____

Does the employer pay more than 50% of the cost? ❑ Yes ❑ No

8. If child does not have other health insurance, could the child get health insurance from a parent's job? ❑ Yes ❑ No

9. Describe the child's disability.

What is the disability? Give us information about it. _____

_____

When did it start? _____

List the doctors, hospitals or other medical providers who have provided medical care and can provide medical records to support the child's medical condition. ***If more space is needed, use another sheet of paper.***

Name of Doctor, Hospital or Other Medical Provider	Medical Provider's Address and Phone Number

10. Do the child's parents, brothers, or sisters under age 19 receive earnings from employment?
❑ Yes – Fill Out Below ❑ No – Go to Question 11

Who Works?	List Employer & Phone # or Write Self Employed	Total Monthly Gross Earnings	How often paid? (weekly, every 2 weeks, twice a month, monthly)

11. Does the child or do their parents, brothers or sisters under age 19 get regular income such as those listed below? ❑ Yes – Fill Out Below ❑ No – Go to Question 12

• Social Security • SSI • Unemployment • Money from Friends/Relatives • Worker's Compensation
• Veteran's Benefits • Child Support (Give the name of child.) • Other (Specify)

Who gets it?	What is it?	How much?	How often?
		$_____	
		$_____	
		$_____	

12. Does the child need coverage for the last 3 months because there are medical bills (paid or unpaid) from this time? ❑ Yes ❑ No

13. Has the child ever received Medicaid in Louisiana? ❑ Yes – Fill Out Below ❑ No

Plastic Medicaid cards can be reactivated and reused. We will not send a new card unless you request one.

Does the child need a new Medicaid card? ❑ Yes ❑ No

This is the end of the application. SIGN BELOW

By signing this application I am giving my permission to the State of Louisiana and its agents to make contacts to verify the information given on this application. Under penalty of perjury I certify all information I have given is true. I also acknowledge that I have received and read the Rights and Responsibilities on the next page.

Sign Your Name Here:_____ **Date:** _____

Rights and Responsibilities

WHAT MEDICAID HAS THE RIGHT TO EXPECT OF YOU

CITIZENSHIP AND IMMIGRATION STATUS: You state that the information about citizenship and immigration status given on this application form is true and correct.

REPORTING THE TRUTH: You state that the information you give on the application form is true and correct. You understand if you purposely give information that is not true OR if you purposely do not tell information that you are supposed to, the person applying may get health benefits that they should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to Medicaid for the bills it paid by mistake.

VERIFICATION OF INFORMATION: You understand that the information you give on this application and about the person applying will be checked. You agree to help Medicaid with that and to let Medicaid get information it needs from government agencies, employers, medical providers, and others.

SOCIAL SECURITY NUMBERS: You understand Social Security numbers will only be used to get information from other government agencies to make a decision on eligibility for the person applying for Medicaid.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting Medicaid, the Department has the right to get money received by the person applying from other sources like insurance payments or lawsuit settlements for services that Medicaid has paid for the person applying.

REPORTING CHANGES: You agree to tell Medicaid within 10 days of these changes: 1) if anyone getting Medicaid moves out of state; 2) if anyone moves in or out of the home; 3) changes in mailing or home address; 4) changes in health insurance and premiums; and 5) changes in income.

CHILD SUPPORT ENFORCEMENT: You understand that Medicaid will only send case information to Child Support Enforcement for medical support if you ask them to. We will make a referral if the parent(s) gets Medicaid unless Medicaid determines you have good cause not to cooperate with Support Enforcement.

WHAT YOU HAVE THE RIGHT TO EXPECT FROM MEDICAID

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

NO DISCRIMINATION: You understand Medicaid cannot treat you differently because of race, color, sex, age, disability, religion, nationality, or political belief. If you think it has, you can call the U.S. DHHS Regional Office for Civil Rights in Dallas, TX at 1-800-368-1019 or write to Louisiana's Department of Health & Hospitals, Human Resources at P. O. Box 4818 Baton Rouge, LA 70821-4818.

OTHER SERVICES: You understand that information about WIC, KIDMED, and other Medicaid services will be sent to the persons that are eligible for Medicaid.

Documents of Proof We May Need From You

Some of these documents of proof will not apply to your application. Let us know if you do not have or cannot get any of these things. We may be able to get them or help you get them.

Copy of health insurance card (front and back) **for child**
If child is not a U.S. citizen, send copy of their Permanent Resident Card (green card) or other form from U.S. Citizenship and Immigration Services.
For children born outside Louisiana, send proof of U.S. Citizenship such as a birth certificate, souvenir birth certificate, U.S. Passport, or adoption papers. Visit www.cdc.gov/nchs for a list of state vital records offices where you may request birth certificates.
Pay stubs from last month showing gross pay (before taxes) or letter from employer. For self-employment, send copies of tax return and all schedule attachments - **for child's parents (legal and natural) and their brothers and sisters under age 19.**
Proof of gross income (before taxes) from child support, Veteran's Benefits, worker's comp, alimony, and any other income that is not from working. Proof could be award letters and 1099 tax statements from the last tax year - **for child, their parents (legal and natural), and brothers and sisters under age 19.**
If Medicaid coverage is needed for any of the three months before the month you apply for Medicaid, send proof of income for each month - **for child, their parents (legal and natural), and brothers and sisters under age 19.**
Copies of all medical reports and Individual Education Plans (IEP) to verify the child's disability.

Please mail or fax the application and documents of proof to us. You may also take it to your local Medicaid office.

Mailing Address:
Family Opportunity Act Medicaid Buy-In Program
P.O. Box 91278
Baton Rouge, LA 70821-9278

Fax:
1-877-523-2987 (toll free)

IMPORTANT PHONE NUMBERS		
	PHONE NUMBER	**TTY TEXT TELEPHONE**
KIDMED (EPSDT)	**1-800-259-4444**	**1-877-544-9544**
CommunityCARE (to request a change of Primary Care Doctor)	**1-800-259-4444**	**1-877-544-9544**
KIDMED and CommunityCARE Physician Referral Assistance	**1-877-455-9955**	
Medicaid Services	**1-888-342-6207**	
Transportation (to request non-emergency transportation)	**1-800-259-1944**	

IMPORTANT WEB SITES	
LaCHIP	**www.LaCHIP.org**
LaMOMS – Medicaid for Pregnant Women	**www.LaMOMS.DHH.Louisiana.gov**
Other Medicaid Programs	**www.Medicaid.DHH.Louisiana.gov**
Find a Doctor Who Accepts Medicaid	**www.La-CommunityCare.com**
KIDMED & CommunityCARE	**www.La-KidMed.com**
Apply for or Renew Your Medicaid	**www.Medicaid.DHH.Louisiana.gov**

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